



State of Louisiana
Department of Health and Hospitals
Health Standards Section

****NOTICE OF NEW LICENSING REGULATIONS****

Date: June 23, 2015

TO: Adult Residential Care Providers

From: Cecile Castello, RN, Section Chief
Health Standards Section

BY: Christopher Vincent, RN, MCPM1
Health Standards Section

RE: Licensing Regulations for Adult Residential Care Providers

New licensing regulations were published in the Louisiana Register, Vol. 41, No. 06 on June 20, 2015. The new regulations are available on the DHH Adult Residential Care Provider website at: <http://dhh.louisiana.gov/index.cfm/directory/detail/702>. The new licensing regulations will apply to all Adult Residential Care Providers including: Level 1- Personal Care Homes, Level 2 - Shelter Care Homes, Level 3 - Assisted Living Facilities, and Level 4 - Adult Residential Care Providers. The licensing regulations shall become effective on **August 15, 2015**. This is the date that providers will be expected to be in compliance with all requirements.

Existing ARC providers are **required to submit** to the department a **written attestation** which certifies that the ARC provider is, and/or shall be in compliance with the new licensing standards by **August 15, 2015**. Additionally, if an existing ARC provider is electing to begin providing **medication administration after August 15, 2015**, the ARC provider shall be **required to submit** to the department a **written attestation** which certifies that the licensing requirements to provide such services have been met. Please complete the attestation forms which are attached to this memo and submit to: DHH Health Standards Section, P.O. Box 3767, Baton Rouge, LA, 70821-3767.

Questions regarding the content of this notice may be directed to Health Standards at 225-342-3204.

This notice and attestation forms are available on the HSS Adult Residential Care Provider Internet address at: <http://dhh.louisiana.gov/index.cfm/directory/detail/702>



Health Standards Section

Attestation Form Adult Residential Care Providers

ARCP Attestation Date:	ARCP Attestation Effective Date:
ARCP Director/Designee:	Designated Contact Person/telephone number:
ARCP Name:	
ARCP Address:	
ARCP Telephone:	ARCP Fax:
Name of ARCP Location Being Attested To:	
Address of ARCP Location Being Attested To:	

This attestation form shall be signed by the Director/Designee of the Adult Residential Care Provider (ARCP).

Attention: Please review the following before signing:

I have reviewed the **Adult Residential Care Provider Licensing Standards** (LAC 48:I. Chapter 68), effective August 15, 2015, and based upon my personal knowledge and belief, I attest that

_____ (ARCP name & location being attested to), effective _____ (date), meets and shall continue to meet the applicable requirements of the **Adult Residential Care Provider Licensing Standards** (LAC 48:I. Chapter 68), effective August 15, 2015.

I further attest that if the above referenced ARCP fails to meet any of the applicable requirements of the specified ARCP Licensing Standards, I, or my designee, shall immediately notify the Health Standards Section of the Department of Health and Hospitals (DHH) of this failure. I understand that the Health Standards Section of DHH, or its representative, has the authority to conduct an on-site survey at any time to determine whether the information provided is accurate and/or whether the ARCP is in compliance with applicable requirements. In accordance with §6801.H(4), failure of an existing ARC provider to submit the required attestation(s) shall be grounds for either denial of license or revocation of licensure.

(Director/Designee only) Signature: _____ Date: _____



Health Standards Section

Attestation Form Adult Residential Care Providers Staff Administration of Medications

ARCP Attestation Date:	ARCP Attestation Effective Date:
ARCP Director/Designee:	Designated Contact Person/telephone number:
ARCP Name:	
ARCP Address:	
ARCP Telephone:	ARCP Fax:
Name of ARCP Location Being Attested To:	
Address of ARCP Location Being Attested To:	

This attestation form shall be signed by the Director/Designee of the Adult Residential Care Provider (ARCP).

Attention: Please review the following before signing.

I have reviewed the **Adult Residential Care Provider Licensing Standards** (LAC 48:I. Chapter 68), effective August 15, 2015, and based upon my personal knowledge and belief, I attest that _____ (ARCP name & location being attested to), effective _____ (date), meets and will continue to meet the applicable requirements for Staff Administration of Medication (Part §6843.C.3).

I further attest that if the above referenced ARCP fails to meet any of the applicable requirements of the specified ARCP Licensing Standards, I, or my designee, shall immediately notify the Health Standards Section of the Department of Health and Hospitals (DHH) of this failure. I understand that the Health Standards Section of DHH, or its representative, has the authority to conduct an on-site survey at any time to determine whether the information provided is accurate and/or whether the ARCP is in compliance with applicable requirements. In accordance with §6801.H(4), failure of an existing ARC provider to submit the required attestation(s) shall be grounds for either denial of license or revocation of licensure.

(Director/Designee only) Signature: _____ Date _____

